Executive Director's Report

Health Services Cost Review Commission

January 13, 2016

Proactive Care Coordination

A key goal of health care delivery improvement both nationally and in Maryland is to improve coordination of care across providers. Providers and government organizations have invested billions of dollars in Electronic Health Records to enable better use of information in providing improved patient centered care. On January 1, 2015, Medicare initiated a professional fee for Chronic Care Management (CCM) that no longer requires a face-to-face visit, but focuses on the provision of care coordination for up to 60 percent of the Medicare population who have 2 or more chronic conditions. Obtaining access to these funds and implementing the CCM program requires electronic sharing of information about patients, which is available 24/7. Implementing effective care coordination is also a core objective of the Maryland All-Payer Model, which relies on better care for complex patients and a focus on chronic care and population health to reduce hospitalizations that could be avoided with community based interventions. The Health Services Cost Review Commission (HSCRC) convened a multi-agency Work Group, the ICN-Care Coordination Work Group, earlier this year to focus on how to implement care coordination in Maryland. This Work Group provided a series of recommendations regarding the aggregation, use and sharing of data, as required, to facilitate this process along with other recommendations regarding infrastructure and organization of care coordination.

The Chesapeake Regional Information System for our Patients (CRISP), the State's designated Health Information Exchange, has been charged with implementing infrastructure and aggregating and distributing data that can aid care coordination activities. A key part of this effort is helping providers identify patients who may benefit from care coordination based on a comprehensive understanding of patient utilization, including utilization at different hospitals. CRISP has been working on the data sharing policy framework as well as the technical solution to support this work.

CRISP worked through their Reporting and Analytics Committee to approve a Cross Facility Data Sharing Policy in September 2015. The policy was based on a legal analysis and opinion provided by CRISP's legal counsel and was subsequently reviewed and approved by Department

of Health and Mental Hygiene (DHMH) counsel in consultation with HSCRC counsel. This policy addresses how CRISP will use hospital case mix data in care coordination efforts. CRISP has had access to confidential hospital case mix data since April 2013, and the use of the data has been governed by a DUA between HSCRC and CRISP. That DUA has since been updated to ensure that any end user of the confidential data, be that a hospital or other provider, strictly adheres to federal and state law and regulation on protecting the confidentiality of Protected Health Information (PHI).

The approved policy allows hospitals to receive comprehensive information on the utilization of their patients, including the utilization at other hospitals. HSCRC case mix data, the CRISP unique ID, and derived analytic enhancements such as readmission flags, Prevention Quality Indicators, and other measures are included in reports. Access to this data is strictly limited in its use for the purposes of care coordination, quality assessment, and quality improvement. Users are individually credentialed and must sign an End User Agreement in which they attest to understanding the limitations on the use of the data.

CRISP will present today regarding the status of the various activities that they have been undertaking to support the implementation of care coordination and system transformation. We plan to have CRISP present an update at each Commission meeting over the next year.

Care Redesign Update

In Maryland, the success of the All-Payer Model is dependent on reducing avoidable utilization that can be achieved through care improvements. Reductions need to be accelerated through the implementation of care coordination and care redesign.

In order to achieve a sustainable decrease in avoidable hospitalizations, care delivery needs to be transformed. In particular:

- Complex and high needs patients need to have enhanced care coordination;
- Long-term and post-acute care providers need to work with hospitals to improve care in ways that will prevent avoidable hospitalizations and re-hospitalizations; and
- Hospitals need to work with primary care and other community based providers and community organizations caring for complex high need patients and patients with multiple chronic conditions in order to coordinate care, improve health, and prevent avoidable hospitalizations.

As previously indicated, HSCRC convened a multi-agency Work Group, the ICN-Care Coordination Work Group, earlier this year to focus on how to implement care coordination in Maryland. In its May report, the ICN-Care Coordination Workgroup laid out a person-centered

approach to transforming the delivery of health care, tailoring care to persons' needs and increasing the focus on complex, high needs individuals and those with chronic conditions. This requires an intense level of intervention for an estimated 25,000 to 40,000 individuals who are not already being supported by payers and need community based case management or other intense interventions on an extended basis. Many of the commercial carriers and Medicaid Managed Care Organizations in Maryland offer case management and also medical homes/primary care focus that extends to patients with higher needs and chronic conditions. The efforts undertaken by health plans are designed to increase care and support provided in the community with the result of better health and avoided hospitalizations. However, Medicare patients in Maryland have few of these supports available, despite their greater need. In order to implement a similar approach for Medicare patients, we estimated the need for chronic care management for an additional 200,000+ Medicare and dually eligible (eligible for both Medicare and Medicaid) beneficiaries who are primarily in fee-for-service, Medicare programs. Bringing care coordination to scale is a large and complex undertaking because it requires the ability to communicate effectively among many parties where little communication has existed in the past, and to execute care management with a large number of patients, delivering the right amount of services. It will be difficult to execute care coordination successfully on a "one-off" basis with each hospital developing its own tools, because successful care coordination necessarily involves the community, comprised of thousands of primary care providers, specialists, case managers, and patients. The ICN-Care Coordination workgroup recommended standardization of certain elements and tools, but left open the approach with the expectation that regional partnerships would tackle some of the issues regarding scaling and standardization at the community level.

Under global budgets, the Commission has included additional dollars in the rates of all hospitals to provide for investments for patients with the goals of improving care and improving health while also reducing avoidable utilization. The intent of these monies is to accelerate the development of care coordination and other interventions relative to these goals, which we refer to as infrastructure investments. Today, we will discuss summaries of three sets of reports from hospitals. HSCRC and DHMH staffs have been working to summarize two of these reports, and consultants have been assisting us with the Regional Partnership reports. I want to thank the staff and our consultants, as well as the hospitals and their partners, for the extensive efforts to review and summarize all of these reports, especially over the holiday season.

- **Global Budget Infrastructure Investment Reports:** The first report summarizes hospital reported expenditures relative to infrastructure. The Commission required that all hospitals report on their investments for fiscal years 2014 and 2015.

- **Regional Partnership Reports:** The second report summarizes the eight regional partnership reports on plans and activities. The Regional Partnerships are a critical part of the State's approach to target high need/high-resource patients in order to improve outcomes, lower costs, and enhance patient experience. The purpose of the Regional Partnerships is to foster collaboration among hospitals together with community-based partners to target services based on patient and population needs, collaborate on analytics, and plan and develop care coordination, chronic care management, and other approaches that reduce avoidable hospitalizations.
- **Strategic Hospital Transformation Plans:** The third report summarizes the Strategic Hospital Transformation Plans or "STPs". During the June 2015 public meeting, the Commission approved a recommendation that required all acute care hospitals in the State to submit a plan to the Commission summarizing their short-term and long-term strategies and incremental investment plans for improving care coordination and chronic care, reducing potentially avoidable utilization, and aligning with non-hospital providers.

In addition to the reports and plans described above, hospitals and their partners have been working on implementation plans. We received 22 applications that involve 45 hospitals requesting an additional $90 million in implementation funding. In June 2015, the Commission designated up to a 0.25% revenue ($40 million) increase to be awarded on a competitive basis. Some hospitals are included in multiple applications. Many applications include multiple hospitals as well as community partners. Before moving forward with additional funding, the staff must determine that funds already provided have been effectively deployed in care coordination activities, and that the plans described in the applications are ready to be implemented and will have a significant near term, positive impact.

An independent review committee consisting of HSCRC, DHMH, CRISP, Maryland Community Health Resources Commission (MCHRC), payer staff and two contracted independent reviewers are meeting on January 19, 2016 to have the first robust review session. Following that meeting, staff will consider options and report back to the Commission at the February 2016 Commission meeting.

Observations and Next Steps

The HSCRC staff is very excited about the ongoing investments and planning that hospitals are undertaking to improve care coordination and to focus on person-centered approaches to chronic care and population health. The care redesign needed to achieve the transformation is dependent on effective planning and implementation involving partnerships with other providers, communities, and patients, as well as scalable approaches that are reliant on people,

processes, and technology. There are already many efforts underway in selected hospitals and communities, and some of the approaches that have been initiated are compelling.

HSCRC, DHMH staff, and external consultants will complete reviews of all of the reports and the implementation proposals. We will discuss the strengths and opportunities being addressed by the plans and proposals. We will also focus on the gaps, both in the scope of the plans set forth and also in the proposals' likely impact and readiness for implementation.

- As needed, we will conduct discussions with a cross-representation of people from regional partnerships and other hospitals and systems, including community providers and other partners that are identified in the plans. We will converse with them for the purpose of gaining an understanding of the extent and scope of their readiness for implementation as well as gaining an understanding of the extent of resources already deployed.
- Through the interviews, we will assess whether hospitals and their partners understand ongoing care management vs. care transitions, the level to which they are actually engaging community providers, their ability to scale, and the long-term sustainability and growth potential of their models. Determine:
    - Which hospitals/regions are already implementing or are ready for implementation?
    - Where are the gaps? What are the supports that need to be employed to address the gaps?
- With the information gained through this process, we will determine strategic next steps with the health care system and stakeholders as a whole. This includes items such as:
    - Strategies for helping the delivery system to transform
    - Centralized processes, resources, technology, technical assistance, and other transformation tools that will be needed and how they may be deployed
    - Policy and model enhancements most appropriate for the ongoing transformation in Maryland
    - How to hold the system accountable for implementation
- As you will hear in the presentations of the reports today, our preliminary assessment in reviewing the plans is that there is some confusion between care coordination for care transitions (post discharge) and ongoing community based care coordination/community based case management. Hospitals were provided significant resources for transition care in past readmission reduction initiatives. The new resources that need to be deployed are focused on reducing avoidable hospitalizations, not just 30-day readmissions. Likewise, we did not see details regarding how hospitals

will support “medical home” development for Medicare patients and other patients with significant chronic care needs, which would also help support primary care and other community providers. The efforts required to bring chronic care management to scale are extensive. For example, they involve: people, processes, and technology to aid in identification of persons most likely to benefit from chronic care management; proactive assignment of selected patients to a provider (and team) that is responsible for the overall management of the patient’s care and coordination with other providers; proactive patient consent and participation processes; completion of assessments and care plans; execution of care management activities; implementing and bringing to scale technology that facilitates coordination across the system; and provision of tools to primary care/medical home teams to help with care management.

We will be especially attentive to these issues in assessing gaps in plans, their readiness to be implemented, and the scalability of the approaches.

Innovations in Graduate Medical Education (GME) Recommendation Report

The Department of Health and Mental Hygiene (DHMH) submitted recommendations for GME reforms to the Center for Medicare and Medicaid Innovation on December 18th, 2015. This report is a requirement of Maryland’s All-Payer Model and was developed by the Innovation in Graduate Medical Education (IGME) Workgroup throughout 2015. The group, chaired by leaders from the University of Maryland and Johns Hopkins Medicine, was composed of a diverse group of senior leaders from across the health care community, including DHMH. Workgroup members included representatives of large and small teaching programs from a variety of specialties and a current resident physician. In addition, in order to gain a wider range of perspectives on the topic of GME, the IGME workgroup convened a broad group of over 100 health care leaders from Maryland and across the nation for a full day summit in May 2015. Based on the findings from this summit and numerous workgroup meetings, the IGME workgroup developed five principles of redesign and seven recommendations on how to reform GME in Maryland so that it can better control costs and improve population health.

The report can be found on the DHMH website: http://dhmh.maryland.gov/gme/SitePages/meetings.aspx. If you have any questions regarding the information contained in this report, please contact Russ Montgomery (Russ.Montgomery@maryland.gov).

Performance for Year 2 of the Maryland All-Payer Model

We have completed Year 2 of the Maryland All-Payer Model. The preliminary All Payer results, which are based on data collected by HSCRC, will be available for the February 2016 Commission meeting. Our Maryland All Payer results will reflect the comparison of hospital revenue increases per capita for calendar year (CY) 2015 versus 2013 to a limit of 3.58% per year, which is compounded for two years and includes savings to date. The Medicare results, which are based on data provided by the federal government, will not be finalized until mid-2016, although we will have preliminary results earlier. The federal government data are based on payments to providers, and there are lags between service dates and payment dates. Also, for Medicare, our requirement is to achieve savings by limiting the growth of hospital expenditures in Maryland Medicare payments per beneficiary in comparison to national growth rates in Medicare payments per beneficiary for CY 2015 versus CY 2013, with all savings included to date. We also have total cost of care "guardrails" that include Medicare payments for inpatient and outpatient services rendered both in acute care hospitals and in non-acute care provider settings, excluding retail prescription drugs. The guardrails are used to monitor changes in costs for areas of expenditures that are not included in our savings requirements. They are in place to ensure that cost shifting from hospital to non-hospital settings does not undermine the hospital savings. These guardrails are calculated on a year over year basis, rather than on a cumulative basis. Because the Medicare calculations are based on payment growth relative to national trends, we need final payment data for Maryland as well as for the nation to complete these calculations. In order to monitor Medicare trends, we use the hospital revenue growth data that we collect from Maryland hospitals on a monthly basis, and we use the interim data provided to us by the federal government for monitoring on an interim basis. However, we are unable to rely on the data from the federal government until most of the claims are paid.

Based on interim results from data collected by HSCRC through November 2015, we expect the All Payer limits will be met. For the Medicare hospital trend that is used to calculate the savings in growth of Medicare hospital costs, our interim data obtained from the federal government through October 2015 show that our CY 2015 over CY 2014 growth is slightly above the national average. The cumulative growth rate of Medicare hospital expenditures in CY 2015 over CY 2013 is still well below the national level. For the total cost of care guardrail, as reported in previous meetings, we have recently started to see some substantial growth in non-hospital costs in CY 2015 relative to reported national growth rates, particularly in post-acute costs. In addition, we are also beginning to see some growth in non-hospital "Part B" costs, which consist of physician and other outpatient claims costs. The data we have from Medicare at this point are accumulated only through July 2015, so it is too early to reach a final conclusion regarding the amount of cost growth for CY 2015. HSCRC's consultants are preparing total cost

of care breakdowns by service and county, and we hope to have these data in hand in the next several weeks. We note that these data are preliminary and the results may change, so we must exercise caution in their use.

We do not have ECMAD data for the current month, due to the holidays and some data resubmissions. We expect to have these data through November 2015 for the February 2016 meeting. Staff will present some statistical data through November 2015 based on the revenue and financial reports that are filed monthly. We will present admissions, days, and ER Visits per thousand population, year over year. These are statistics monitored by the payer industry. These statistics show reductions in admissions and days, and flattening of ER trends. While the trends are moving in the right direction, we need a larger reduction in Medicare utilization to balance the Maryland rate update provision, based on the very preliminary national Medicare trends we are seeing right now.

Planning for Ongoing Implementation and Application to Extend the All-Payer Model

With the State's All-Payer Model having completed its second full year of operations, DHMH and HSCRC are reconvening the Advisory Council. The Council, originally charged with recommending guiding principles for the implementation of the new model, is now needed to provide advice on the potential future directions for Maryland's health care improvement and population health initiatives and the All-Payer Model progression. In order to create sustainability of the existing All-Payer Model, the delivery system needs to develop partnerships and infrastructure that will help it improve care with a resulting reduction in avoidable hospitalizations and costs. Additionally, the Agreement with the Centers for Medicare & Medicaid Services (CMS) and Maryland calls for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate. HSCRC staff is engaged in a planning process with stakeholders to organize for these upcoming meetings.

The first meeting will be held on February 3rd, 2016 at the Maryland Hospital Association Conference Center. Meeting dates, agendas, and materials will be posted on the HSCRC website.

HSCRC and DHMH will engage in active discussions with CMS about this planning process and the approach and vision that result from these efforts.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Reviewing implementation plans and conducting discussions regarding proposals, plans, and reports that have been provided to HSCRC for the purpose of assessing and understanding implementation progress and gaps, and readiness to accelerate community based care coordination and management.
- Organizing and preparing for the annual update.
- Reviewing several rate applications for capital that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and also to progress toward a focus on outcomes and cost across the health care system.
- Preparing to work with DHMH and stakeholders to focus on ensuring success of the All-Payer Model and providing a proposal no later than January 2017 as required under the Agreement with CMS.